

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11426

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Rural		b. COUNTY Harford	
c. LENGTH OF STAY IN 1b 17 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Aberdeen R.D., # 3 Box 318	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last William C. Bauer		4. DATE OF DEATH Oct. 31, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 16, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Proprietor	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Frank Bauer		14. MOTHER'S MAIDEN NAME Anna Grace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 212 03-9355 17. INFORMANT Augusta E. Bauer, Aberdeen, Maryland.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Terminal Coronary Occlusion Coronary Arteriosclerosis Terminal 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ to _____, and that death occurred at _____ M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 8 Low St - Aberdeen, Md. - DATE SIGNED 11-3-59	
ACTUAL SIGNATURE <i>Victor P. Robinson</i>		PHYSICIAN'S NAME (Type) Victor P. Robinson	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 4, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Trinity Lutheran		22d. LOCATION (City, town, or county) (State) Joppa, Harford, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard R. McElroy</i>		ADDRESS Abingdon, Maryland	
		24a. REC'D BY REGISTRAR DATE NOV 5 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>

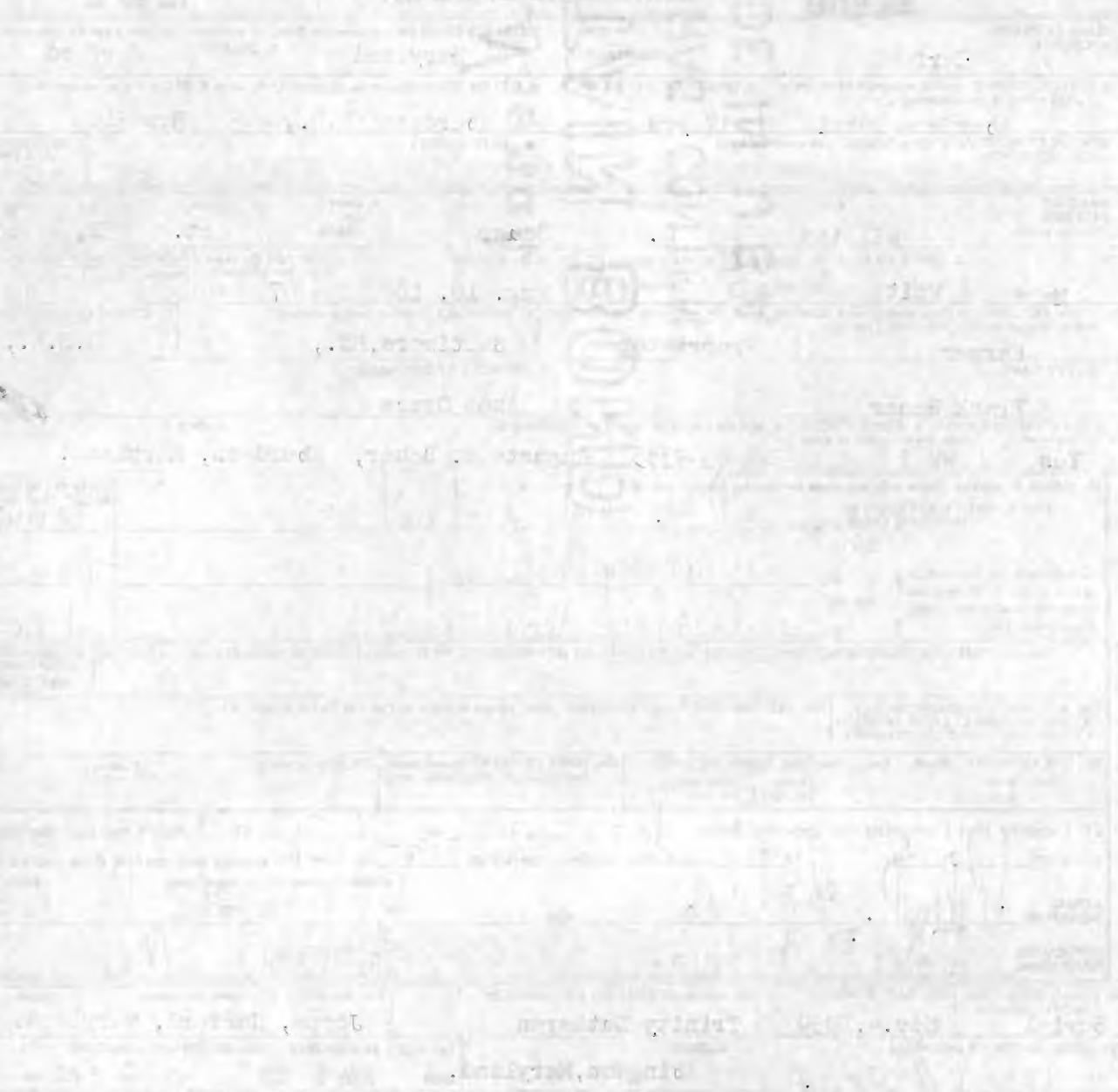
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

21 АВГУСТ - 1955 ГОДА. ВЪВ ВЪДРОГИЯ

НТАРЮЩИЙ СТАДИОН

9.00



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11445 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G250 10/22/59 1w/c

Reg. Dist. No.

11427

1. PLACE OF DEATH a. COUNTY Harford County		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace, Maryland		b. COUNTY Kent	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS 1445	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)		First Haywood	Middle Brown	Last	4. DATE OF DEATH October 11, 1959	Month 19	Day	Year
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Apr. 20, 1932	Age 27 26 yrs.	9. AGE (In years last birthday) 26 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Various		11. BIRTHPLACE (State or foreign country) Kent CO. Maryland		12. CITIZEN OF WHAT COUNTRY? USA		

13. FATHER'S NAME Oscar Brown		14. MOTHER'S MAIDEN NAME Helen Ford						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. Korean 220-26-9093		17. INFORMANT Marie Wilmer		Address RFD Worton, Md.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>fracture skull</u>								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ DUE TO (c) _____								

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) auto accident auto object type							
20c. TIME OF INJURY Hour 6:00 PM 10-11-59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40		20f. (City or town) Havre de Grace, Harford Md.		(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
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ACTUAL SIGNATURE <u>Gerald C Palmer</u>		DATE SIGNED 10-12-59							
EXAMINER'S NAME (Type) Gerald C. Palmer, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/15/59		22c. NAME OF CEMETERY OR CREMATORIAL Coleman's Cem.		22d. LOCATION (City, town, or county) RFD Worton, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Wallay</u>		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE OCT 16 '59		24b. REGISTRAR'S SIGNATURE <u>Charles S. Krause</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File Pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11428

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Bel Air		c. LENGTH OF STAY IN 1b 35 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allibone Rd.		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Bel Air	
3. NAME OF DECEASED (Type or print) Carrie		First L.	Middle Burkins
4. DATE OF DEATH October 11, 1959		Last	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 6, 1874
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles M. Burkins		14. MOTHER'S MAIDEN NAME Clevia Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 153-0	
17. INFORMANT Mrs. Clevia Kohler, Rt. # 2, Street, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma		INTERVAL BETWEEN ONSET AND DEATH ?	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Initial lesion: Carcinoma of Cecum		?	
DUE TO (b) None		?	
(c)		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 28, 1937 to October 11, 1959 that I last saw the deceased alive on Oct. 13, 1959 , and that death occurred at 7:20pM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED Oct. 15, 1959			
ACTUAL SIGNATURE Willard P. Hudson, M.D.			
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/17/1959	
22c. NAME OF CEMETERY OR CREMATORY Deer Creek Methodist		22d. LOCATION (City, town, or county) Forest Hill, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Fitter		ADDRESS 10, Broadway & Williams St. Bel Air, Maryland	
24a. REC'D BY REGISTRAR DATE OCT 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11462 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

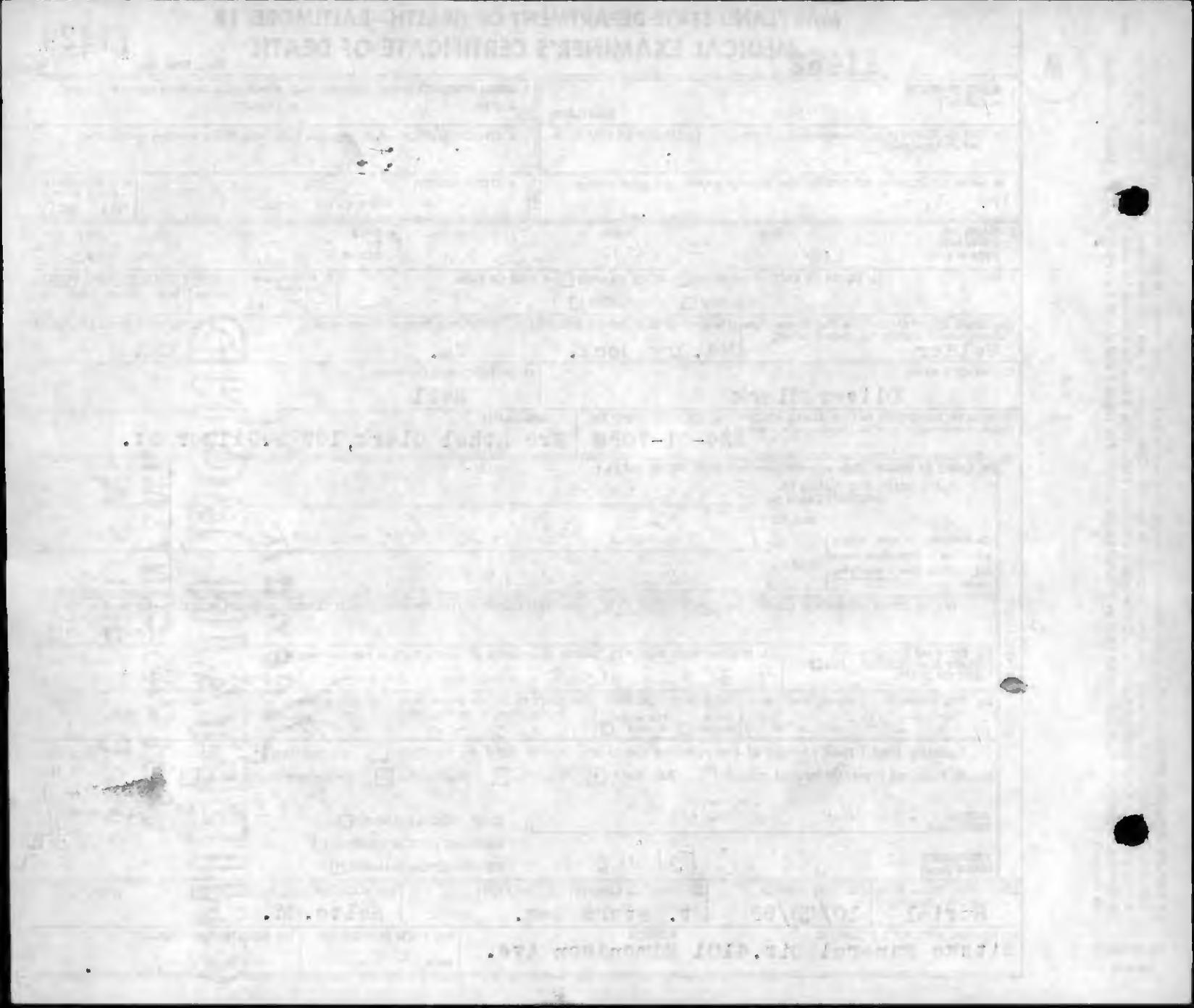
11429

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b <i>MARYLAND</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>ns Route 40</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 5801-4</i>	
3. NAME OF DECEASED (Type or print) <i>Fred</i>		First <i>5</i>	Middle <i>nick</i>
4. DATE OF DEATH <i>10/20/59</i>		Last <i>Clark</i>	Month Day Year Oct 20 1959
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>1-27-12</i>	9. AGE (In years last birthday) <i>47 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Welder</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Md. Dry Dock.</i>	
11. BIRTHPLACE (State or foreign country) <i>Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Oliver Clark</i>		14. MOTHER'S MAIDEN NAME <i>Bell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>816X</i>		16. SOCIAL SECURITY NO. <i>234-01-7058</i>	
17. INFORMANT <i>Mrs Ethel Clark, 109 S.Gilmor St.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Evisceration brain</i> DUE TO (b) <i>Fracture arms, legs, spine,</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <i>ribs, skull</i> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident, auto - auto type</i>			
20c. TIME OF INJURY Hour <i>11:30</i> p.m. Month, Day, Year <i>10-20 59</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>ns Route 40</i>
20f. (City or town) <i>Towson</i>		(County) <i>Harford</i> (State) <i>MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> <i>Gerald C Palmer</i>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>10-21-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/23/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Peters Cem.</i>
22d. LOCATION (City, town, or county) <i>Balto. Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Witzke Funeral Dir. 4101 Edmondson Ave.</i>		ADDRESS <i>Witzke Funeral Dir. 4101 Edmondson Ave.</i>	24a. REQ'D BY REGISTRAR DATE <i>OCT 23 '59</i>
		24b. REGISTRAR'S SIGNATURE <i>John S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11430

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM43. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARVE DE GRACE		c. LENGTH OF STAY IN lb 10 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harfard Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First James	Middle NICHOLAS	Last Fowler
4. DATE OF DEATH Oct 31 1959	Month Oct	Day 31	Year 1959
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct 31 1959
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 30 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER		10b. KIND OF BUSINESS OR INDUSTRY TAVERN	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES N. FOWLER SR.		14. MOTHER'S MAIDEN NAME MARY BELLE HASH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. M.J.N. FOWLER SR. DARLINGTON, MD	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) HARFORD		(County) MD.	
		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Willie V. Fowler</i>	DATE SIGNED Nov 1 1959		
EXAMINER'S NAME (Type)	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-3-1959	22c. NAME OF CEMETERY OR CREMATORIUM MT ZION Cem.	22d. LOCATION (City, town, or county) HARFORD
		(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Madison Mitchell, Harve de Grace, MD.</i>		ADDRESS	24a. REC'D BY REGISTRAR NOV 4 '59
			24b. REGISTRAR'S SIGNATURE <i>Charles S. Keene</i>

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W. 29th Street
W. 29th Street

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possible to know (reference)

> x x

PM 10th x

W. 29th Street

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11431

11446 CERTIFICATE OF DEATH

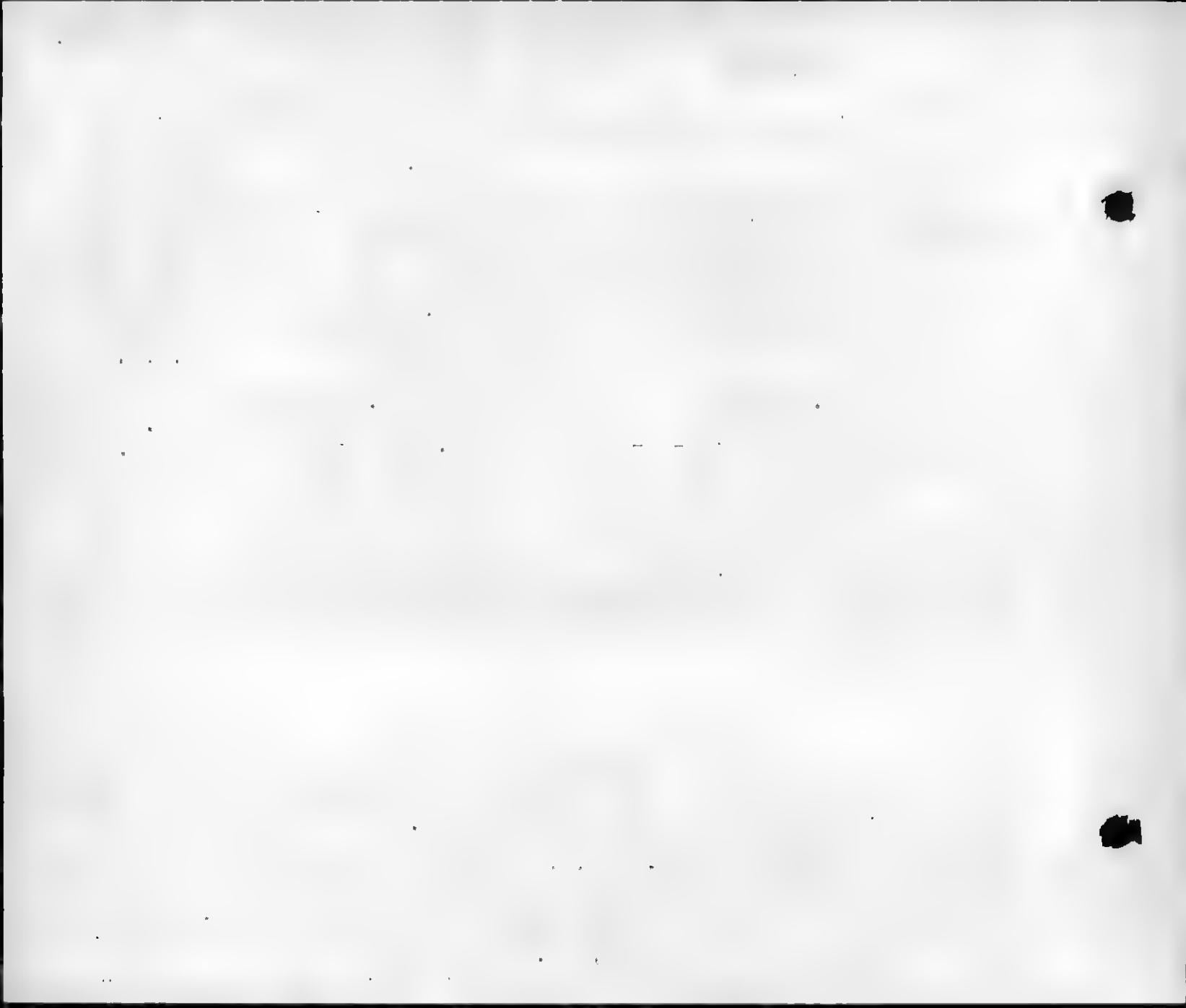
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 East Bel Air Avenue		d. STREET ADDRESS 11 East Bel Air Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THOMAS		First JOSEPH	Middle GEBHART
4. DATE OF DEATH October		Month 9.	Day 19
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 25, 1939		9. AGE (In years last birthday) 20 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas F. Gebhart		14. MOTHER'S MAIDEN NAME Ruth C. Boulden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 215-34-6291	
17. INFORMANT Thomas F. Gebhart, Aberdeen, Md.		Address 11 E. Bel Air.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR	
DUE TO <i>Pulmonary Oedema</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		2 days -	
DUE TO <i>Cerebral Hemorrhage.</i>			
(c) <i>Leukemia - Hodgkin's Disease</i>		5 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1959, to <u>Oct. 9</u> , 1959, that I last saw the deceased alive on <u>October 9</u> , 1959, and that death occurred at <u>5:10 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>200 N. Union Avenue</u> DATE SIGNED <u>10/10/59</u>	
ACTUAL SIGNATURE <u>Frank Wolbert M.D.</u>		PHYSICIAN'S NAME (Type) <u>Frank Wolbert, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/59	
22c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens, Bel Air, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barrueg</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 14 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1144 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

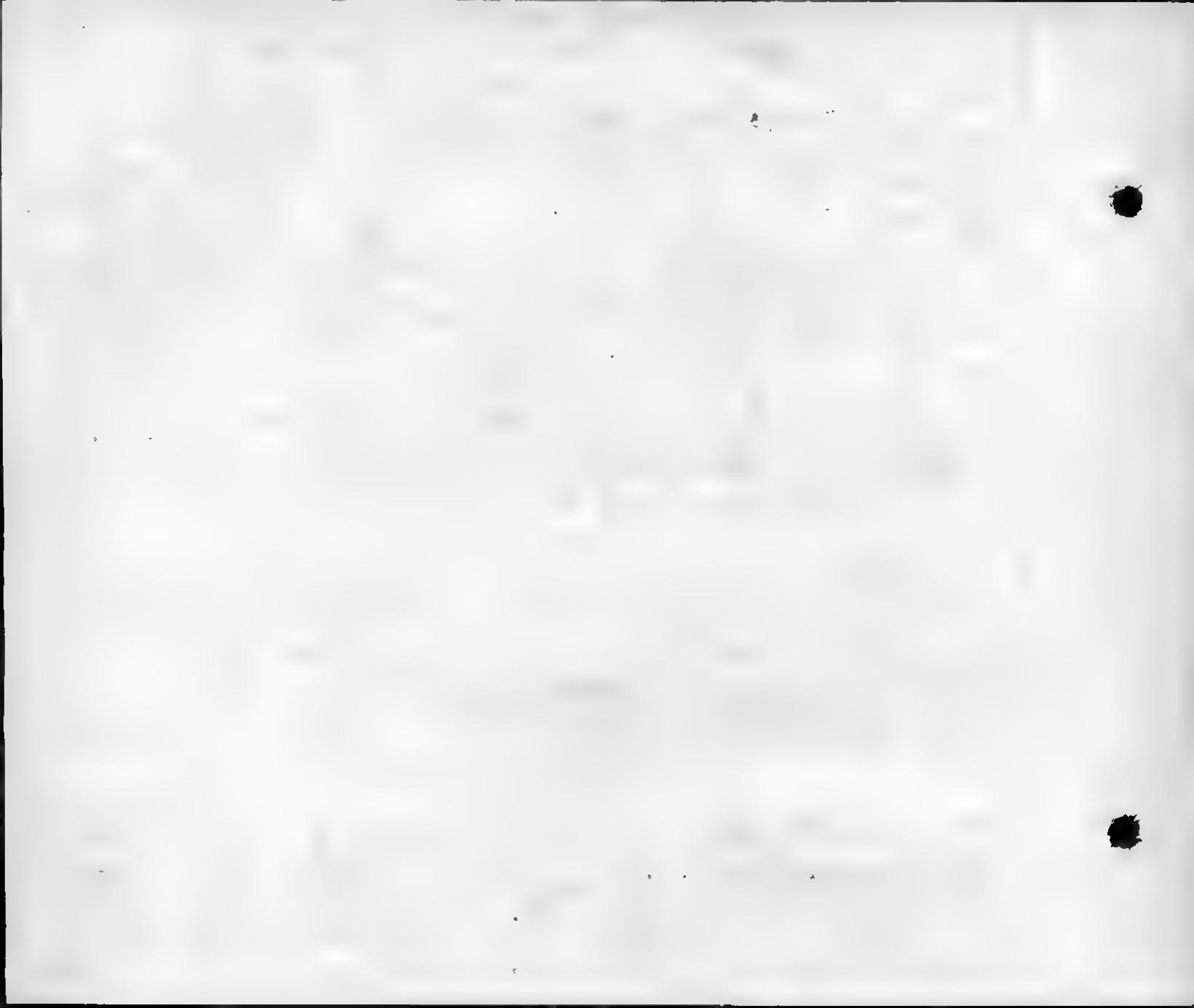
Reg. Dist. No.

11432

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar [redacted] for burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY	Harford County		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	a. STATE Maryland		b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	DOA Harford Memorial Hospital		c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Havre de Grace	DOA		Worton	Worton				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Havre de Grace - Harford Memorial Hosp.		d. STREET ADDRESS	d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Earl Gibbs				October	11		1959	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years from birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.		
M	C	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 13, 1893	65 yr.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?					
Laborer	various	Kent Co. Maryland	USA					
13. FATHER'S NAME	Richard Gibbs		14. MOTHER'S MAIDEN NAME	Emma Clayton				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.		17. INFORMANT	Address				
no	110-09-1810		Mrs. Linara Brown	RFD Worton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) fracture skull								
DUE TO								
Conditions, if any, which goe rise to immediate cause (a), stating the underlying cause lost. (b)								
DUE TO								
cause lost. (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) auto accident auto object type							
20c. TIME OF INJURY Month, Day, Year Hour 6 PM p. m. 10-11-59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
			Route 40	Havre de Grace Harford Maryland				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 10-12-59			
EXAMINER'S NAME (Type) Gerald C. Palmer, M. D.								
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/17/59		22c. NAME OF CEMETERY OR CREMATORIUM Coleman's Cem.		22d. LOCATION (City, town, or county) near Worton, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE OCT 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11433

11448

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		d. STREET ADDRESS 28 Church Green	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 28 Church Green				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELIZABETH		First WATSON	Middle GIFFORD	Last GIFFORD	4. DATE OF DEATH October	Month 18	Day 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Jan. 11, 1879	9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book-keeper, Ret.		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Watson Gifford		14. MOTHER'S MAIDEN NAME Elizabeth McCullough					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. 181-22-4513-A		17. INFORMANT Elizabeth Hodgson, Oxford, Penna.		Address 51 N. 3rd. St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Heart Failure		INTERVAL BETWEEN ONSET AND DEATH terminal		1 month	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1950		20f. (City or town) October 18	(County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE						ADDRESS (Street, city or town, state) 8 Law Street	DATE SIGNED 10-19-59
PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.				Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/59		22c. NAME OF CEMETERY OR CREMATORIAL West Nottingham Cem.		22d. LOCATION (City, town, or county) Cecil County, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Tarrington		Tarring Funeral Home Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE OCT 22 '59		24b. REGISTRAR'S SIGNATURE John S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11449

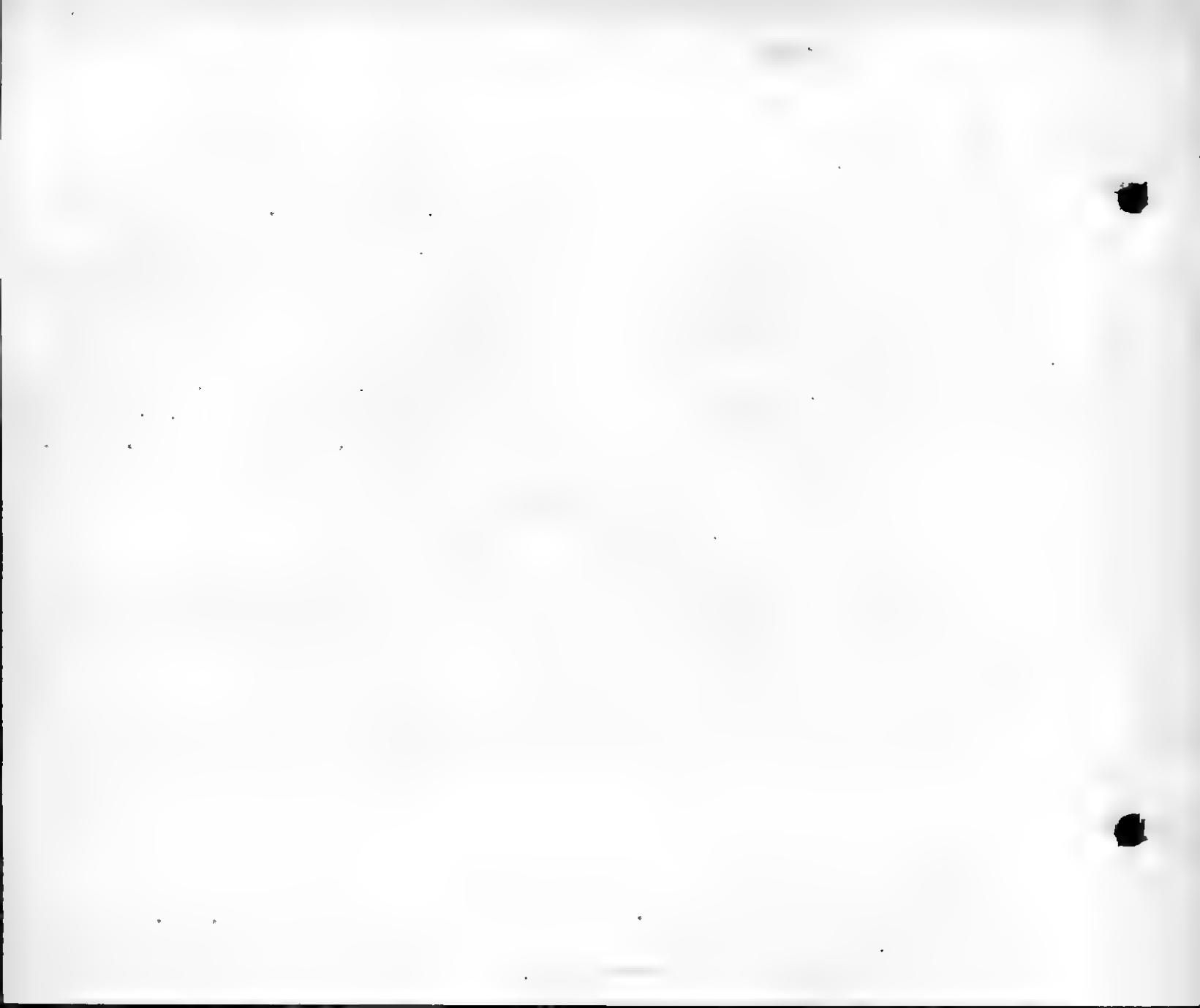
CERTIFICATE OF DEATH

11434

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUTE DE GRACE		b. COUNTY Cecil	
c. LENGTH OF STAY (In 1b RURAL and give nearest town) 41 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hospital		d. STREET ADDRESS 51 Granite Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GARY	Middle Griffin	Last October 2 1959
4. DATE OF DEATH	Month October	Day 2	Year 1959
5. SEX MALE	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Elmer Johnson		14. MOTHER'S MAIDEN NAME Joyce Marie Griffin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO INFORMANT Address Port Deposit Lenabel Griffin, 51 Granite Ave. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 571.0 DUE TO Streptococci · Broncho Pneumonia. INTERVAL BETWEEN ONSET AND DEATH 7 days.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Streptococci · (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pyrexia - Coughing + Headache.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-1-59 to 10-11-59 , that I last saw the deceased alive on 10-10-1959 , and that death occurred at 5:45 AM , from the causes and on the date stated above. ACTUAL SIGNATURE L. J. McLean PHYSICIAN'S NAME (Type) L. J. McLean			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 10-12-1959	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zoar		22d. LOCATION (City, town, or county) (State) Conowingo, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Patterson, Jr. 207182XV2		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR DATE OCT 13 '59		24b. REGISTRAR'S SIGNATURE Charles S. Moore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11435

11463

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. The certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland		b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		d. STREET ADDRESS Box 226 RD # 1	
d. NAME OF HOSPITAL (If not in hospital, give name and address) OR INSTITUTION US ARMY HOSPITAL ABERDEEN PROVING GROUND, MARYLAND				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF KAREN (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Female	White	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	Oct 17, 1959	October	17	19 59
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years from birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
Female	White	N/A	Oct 17, 1959	35			
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jerry Francis Haberer		14. MOTHER'S MAIDEN NAME Phyllis JoAnn Crook					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N/A		16. SOCIAL SECURITY NO None		INFORMANT Father		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) An encephaly DUE TO 750X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 17, 1959 , to Oct 17, 1959 , that I last saw the deceased alive on Oct 17, 1959 , and that death occurred at 12:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Hans A. Keuls 17 Oct '59							
PHYSICIAN'S NAME (Type) HANS A KEULS Capt MC		M.D. USAH-APC 17 Oct '59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/1959		22c. NAME OF CEMETERY OR CREMATORIAL Post Cemetery		22d. LOCATION (City, town, or county) Aberdeen Proving Ground (State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE John S. Barron		ADDRESS Aberdeen Rd.		24a. REC'D BY REGISTRAR OCT 23 '59		24b. REGISTRAR'S SIGNATURE John S. Thorne	



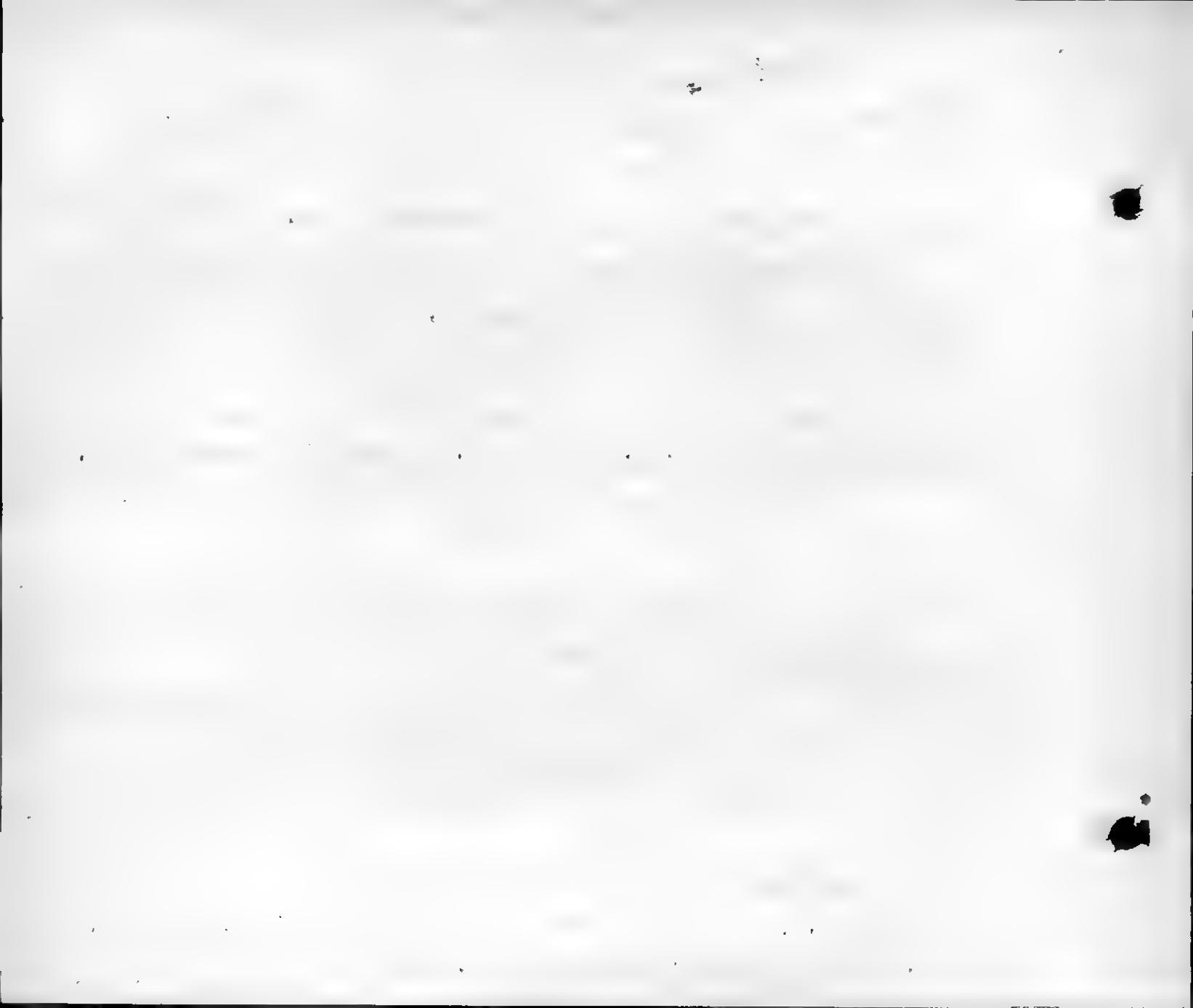
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11436

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Hall		c. LENGTH OF STAY IN 1b Years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Harford	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Norrisville Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Hall		f. STREET ADDRESS Norrisville Rd.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Jacob Willard Hammond		First	Middle	Last	4. DATE OF DEATH October 1 1959	Month	Day	Year	
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 16, 1888	9. AGE (In years lost birthday) 71 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214.05.3954		17. INFORMANT John W. Hammond 2108 Lukewood Ave. 7		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. DUE TO		Chronic congestive heart failure							
(b) DUE TO		Chronic myocarditis + pericarditis							
(c) DUE TO		Chronic myocarditis + pericarditis						Prob. 1/2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from Sept. 30, 1959 to Oct. 1, 1959 , that I last saw the deceased alive on Sept. 30, 1959 , and that death occurred at 4:50 A.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Stewartstown, Pa.	
ACTUAL SIGNATURE Norman H. Gemmill		M.D.						DATE SIGNED Oct. 1, 1959.	
PHYSICIAN'S NAME (Type) Norman H. Gemmill									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 5, 1959		22c. NAME OF CEMETERY OR CREMATORY Baltimore		22d. LOCATION (City, town, or county) Baltimore		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury		ADDRESS 6411 Windsor Mill Rd.		24a. REC'D BY REGISTRAR Arthur & Francis		24b. REGISTRAR'S SIGNATURE Arthur & Francis			
VS A15 (4) 1SM 10/57		DATE OCT 6 '59							



Item 18 Film 253 12-7 MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11437 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
 HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 2 and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS. A15ME
 5M 7/59

1. PLACE OF DEATH
 a. COUNTY

HARFORD

b. CITY OR TOWN (If out da corporate limits, write RURAL and give nearest town)

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Harford Memorial Hospital

3. NAME OF
 DECEASED
 (Type or print)

First

Middle

Last

HARRIS

5. SEX
 Male

6. COLOR OR RACE
 Colored

7. MARRIED NEVER MARRIED
 WIDOWED DIVORCED

8. DATE OF BIRTH

Nov. 17, 1924

4. DATE
 OF
 DEATH

Month
 October
 Day
 30

Year
 1959

9. AGE (In years
 last birthday)
 34 yrs.

10. IF UNDER 1 YEAR
 Months
 Days

11. IF UNDER 24 HRS.
 Hours
 Min.

10a. USUAL OCCUPATION (Give kind of work
 done during most of working life, even if retired)

Trackman

10b. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Harford Co., Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William F. Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

Yes WW II

16. SOCIAL SECURITY NO.

17. INFORMANT

218 12-26-7 Bernice E. Harris, Joppa, Maryland

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a)

Interstitial myocarditis

INTERVAL BETWEEN
 ONSET AND DEATH

722
 Conditions, if any, which
 gave rise to immediate cause
 (a), stating the underlying
 cause last

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)

19. WAS AUTOPSY
 PERFORMED?
 YES NO

20a. EXTERNAL CAUSE WAS
 PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
 Hour a.m.
 p.m.

20d. INJURY OCCURRED
 While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner

MEDICAL CERTIFICATION

ACTUAL
 SIGNATURE

W. Bradley King, Jr., M.D.

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED

10/30/59

22a. BURIAL, CREMATION,
 REMOVAL (Specify)

Burial

22b. DATE THEREOF

Nov. 2, 1959

23. FUNERAL DIRECTOR

Howard K. Mc Comas & Son

John Wesley

ADDRESS

Abingdon, Maryland.

24e. REC'D BY REGISTRAR

NOV 4 '59

DATE

24f. REGISTRAR'S SIGNATURE

Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 11438

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Pylesville		b. COUNTY Harford	
c. LENGTH OF STAY IN 1b 22 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pylesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eck Middle Louisville Last Hash		4. DATE OF DEATH Month October Day 12, 1959 Year	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH April 27, 1877	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Fox, Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas B. Hash		14. MOTHER'S MAIDEN NAME Melinda Brewer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT 199-07-8318 Mary B. Hash, Pylesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days Cerebral Hemorrhage arteria schizans	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Chronic myocarditis, hypertension	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 1950, to <u>Oct 11</u> , 1959, that I last saw the deceased alive on <u>Oct 10</u> , 1959, and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Edward W. Tyson</u> M.D. <u>Fawn Grove, Pa.</u> DATE SIGNED <u>Oct 11, 1959</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 14, 1959	
22c. NAME OF CEMETERY OR CREMATORIAL Oak Grove		22d. LOCATION (City, town, or county) Belair, Harford Co., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Barkins		ADDRESS Delta, Penna.	
		24a. REC'D BY REGISTRAR DATE OCT 15 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 4 Film G252 11/20/59 iwk
11451 CERTIFICATE OF DEATH

11439
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Starford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 335 Strawberry		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Mamie Holmes		First	Middle	4. DATE OF DEATH Oct. 23 1959	Month Day Year
5. SEX Female Negro		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1876	9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Worker		10b. KIND OF BUSINESS OR INDUSTRY Private Family		10c. BIRTHPLACE (State or foreign country) House de Grace, Md. U.S.A.	
13. FATHER'S NAME George Weeks		14. MOTHER'S, MAIDEN NAME Harriett Haycock		12. CITIZEN OF WHAT COUNTRY? Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mrs. Leon Coopster, H. S. L. M.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 22 1959 to Oct 23 1959, that I last saw the deceased alive on Oct 23 1959, and that death occurred at 730 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 10/26/59	
ACTUAL SIGNATURE John B. Wachsmuth, M.D.		PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 27 1959		22c. NAME OF CEMETERY OR CREMATORIUM St. James Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Otelia J. Bullock, House de Grace		ADDRESS		24a. REC'D BY REGISTRAR OCT 29 1959	
				24b. REGISTRAR'S SIGNATURE Ernest J. Riva	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1145 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11440

1. PLACE OF DEATH a. COUNTY		Harford County D o A Harford Mem. Hospital MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Harford Grace		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b				e. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Harford Memorial Hospital		R D 1	
3. NAME OF DECEASED (Type or print)		First Eugene Middle Enoch Last J. T. 4. DATE OF DEATH		Month October Day 11 Year 1959	
5. SEX M		6. COLOR OR RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 3-21-33 9. AGE (In years (last birthday) 26 yrs.	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY carpenter 11. BIRTHPLACE (State or foreign country) Kent CO. Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Reuben Jones		14. MOTHER'S MAIDEN NAME Addie Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Korean		16. SOCIAL SECURITY NO. 220-28-2203		17. INFORMANT Addie Jones RFD Worton, Md. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull					
819X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) A no accident, auto - object type			
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> a.m. Oct 11 1959 p.m. <input type="checkbox"/> <input type="checkbox"/> White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 48 20f. CITY OR TOWN (County) Harford County (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE Gerald C Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-11-59	
EXAMINER'S NAME (Type) Gerald C Palmer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/15/59		22c. NAME OF CEMETERY OR CREMATORIAL HFD Worton, Md.	
22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Wallay		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR OCT 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thorne	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11466 CERTIFICATE OF DEATH

Reg. Dist. No. 11466

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		b. COUNTY <i>Harford</i>	
c. LENGTH OF STAY IN 1b <i>20 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rural #1 - near Paradise Rd.</i>		d. STREET ADDRESS <i>near Paradise Road</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Jessie</i>		First	Middle
			Last
		<i>Kelly</i>	
4. DATE OF DEATH <i>Aug. 20 1894</i>		Month	Day
		<i>10</i>	<i>28</i>
		Year	<i>1894</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
			8. DATE OF BIRTH <i>Aug. 20 1894</i>
		9. AGE (In years last birthday) <i>85</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Dunker Industry</i>	10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>
			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Samuel Kelly</i>		14. MOTHER'S MAIDEN NAME <i>Mariie Banks</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>Yes War #1.</i>		16. SOCIAL SECURITY NO <i>220-03-1007</i>	17. INFORMANT <i>Hattie T. Kelly - Aberdeen #1-2nd.</i>
			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>151x</i>		DUE TO <i>CARDIO-VASCULAR COLLAPSE</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <i>CARCINOMA OF STOMACH</i>	
		DUE TO (c)	
		UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10-24</i> , 1959, to <i>10-28</i> , 1959, that I last saw the deceased alive on <i>10-24</i> , 1959, and that death occurred at 1:00 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>421 CONGRESS AVE.</i>	
ACTUAL SIGNATURE <i>Bernice D. Hirsh</i>		DATE SIGNED <i>10/29/59</i>	
PHYSICIAN'S NAME (Type) <i>DR. G. D. Hirsh</i>		HARVE DE GRACE MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/31/1959</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Union Methodist</i>	22d. LOCATION (City, town, or county) (State) <i>Aberdeen P. O. - Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Tarras</i>	ADDRESS <i>Aberdeen, Maryland</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 3 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Tarras</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please move carbon copies. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57



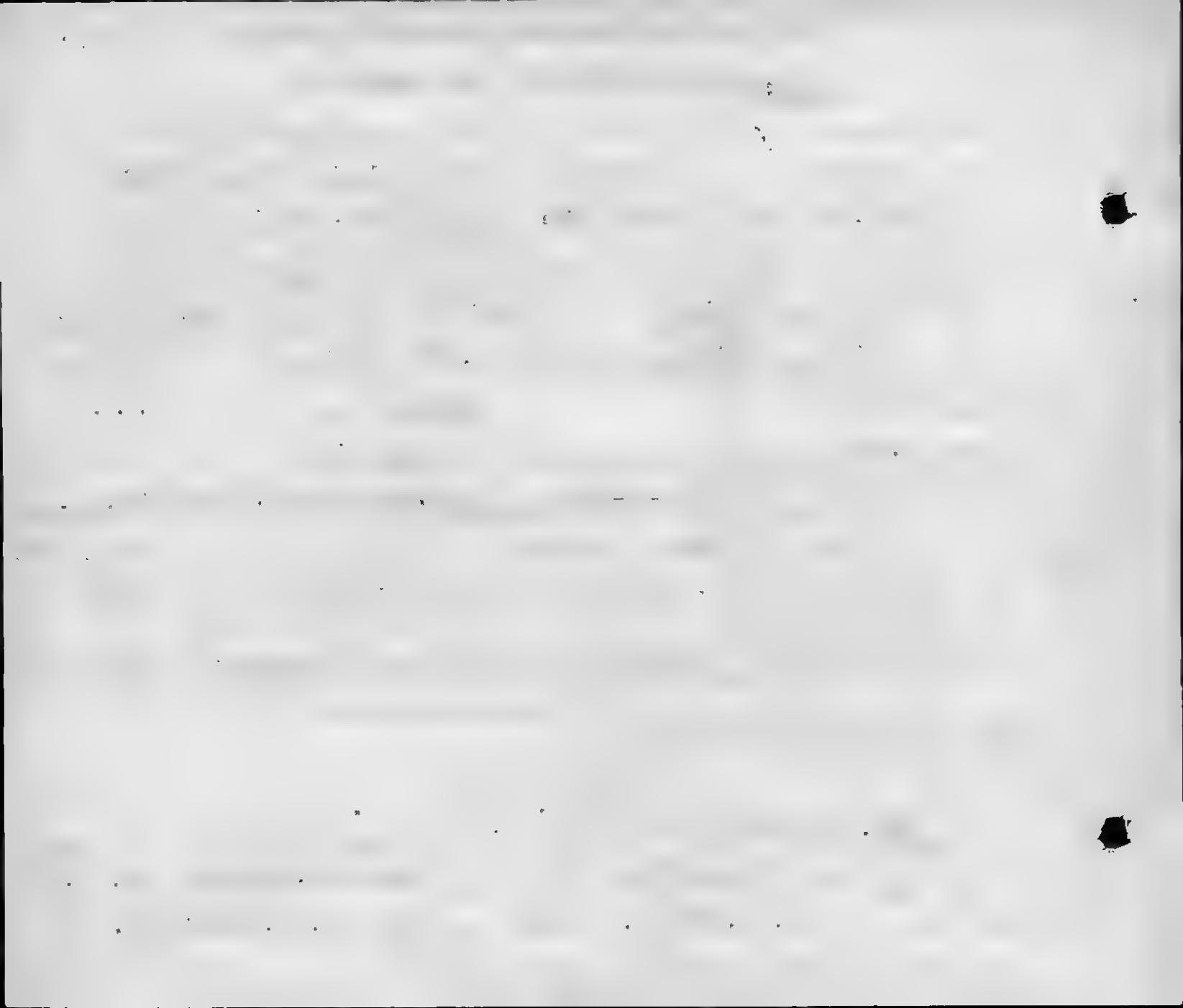
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1142

11467 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Harford CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural, Bel Air HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Bel Air STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) Joseph (Middle) Milton (Last) Kelly (Type or Print)				4. DATE OF DEATH October 29 (Month) 19 59 (Day) (Year)			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Specified</i>	8. DATE OF BIRTH January 28, 1896	9. AGE last birthday 63	10. IF UNDER 1 YEAR Months 0 Dey 0		IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James M. Kelly				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO. 218-18-1852			
17. INFORMANT & ADDRESS Mrs. Marion Kelly, Forest Hill, Md.				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 1. IMMEDIATE CAUSE Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH Sudden death			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO Chr. hypertensive cardiovascular disease				15 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Three previous episodes of cerebral thrombosis				Ist 9 yrs ag			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) Forest Hill, Maryland		(County) Harford (State)	
21d. TIME OF INJURY (Month) Oct. (Day) 29 (Year) 1959		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. of work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 25, 1959, to Oct. 29, 1959, that I last saw the deceased alive on Sept. 25, 1959, and that death occurred at 6:15 AM, from the causes and on the date stated above. SIGNATURE <i>James M. Kelly</i> M.D. ADDRESS Forest Hill, Maryland DATE SIGNED Oct. 29, 1959 ADDRESS St. Ignatius LOCATION (City, town, or county) Bel Air, Md.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 31, 1959		NAME OF CEMETERY OR CREMATORIAL St. Ignatius		24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <i>Charles S. Evans</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph J. T. T. Bel Air, Md.</i>		ADDRESS					
DATE NOV 2 '59							



INSTRUCTIONS

TO ATTEND PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11443

11468 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place) Bel Air Rural	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bel Air	COUNTY Harford (If rural give location) Thomas Run Road
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Thomas (Middle) Nice (Last) Livezey Jr.		10	(Month) 10 (Day) 18 (Year) 1959
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 11-25-1880
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Thomas Nice Livezey Sr.		14. MOTHER'S MAIDEN NAME Sylvania Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or blank.)		16. SOCIAL SECURITY NO. 218-26-7120	
17. INFORMANT & ADDRESS Miss Margaret Livezey Bel Air, Md. 21014 (325-11)		18. MEDICAL CERTIFICATION Cerebral Vascular Accident Hypertensive C-V-D	
19a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 44 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 20 YEARS	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21e. M.		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from.....		alive on..... and that death occurred at.....	
Signature Robert Bartholomew		ADDRESS (Street, city, town, state) Forest Hill, Md.	
DATE SIGNED 10-19-59			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10-21-59	
24. REC'D BY REGISTRAR		NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery	
DATE OCT 21 '59		LOCATION (City, town, or county) Bel Air, Maryland	
REGISTRAR'S SIGNATURE Curtis S. Evans		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph J. Feltz Bel Air, Maryland	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1 items 5,14 2-1 32,3 1 1-1 1-1 1-1 et

11469

CERTIFICATE OF DEATH

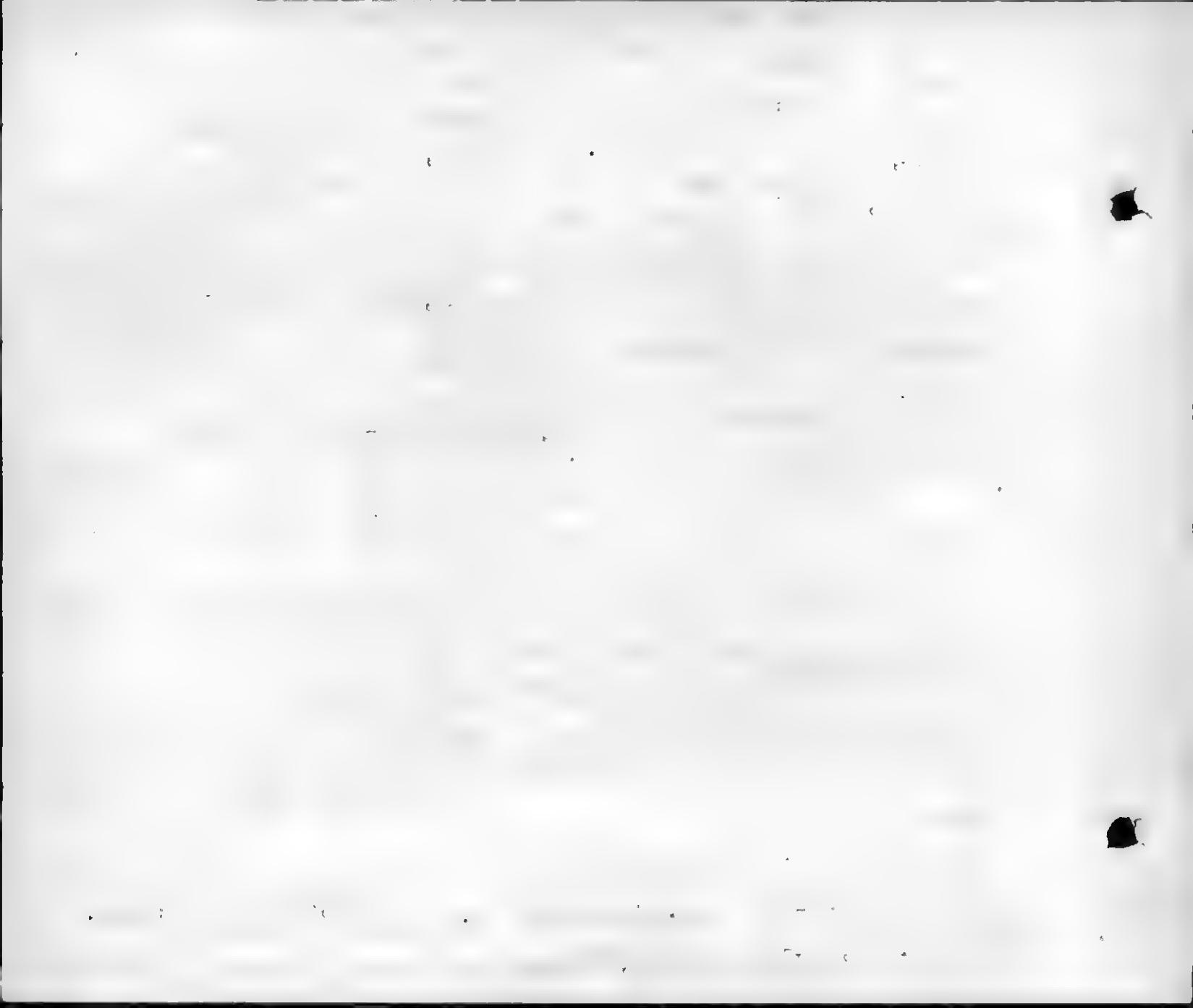
Reg. Dist. No.

1144

1. PLACE OF DEATH a. COUNTY Harford Co:Maryland MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland b. COUNTY Harford County									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston, Maryland			c. LENGTH OF STAY IN 1b About 3 Wk.									
d. NAME OF HOSPITAL (If in hospital, give street address) OR INSTITUTION Watervale Road Fallston, Maryland			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston, Maryland									
3. NAME OF DECEASED (Type or print) MARY SUSAN LUCHANSKY			First	Middle	Last	4. DATE OF DEATH OCT 7 1959	Month	Day	Year			
5. SEX Female Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1895		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR 11 Months	IF UNDER 24 HRS 22 Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (State or foreign country) Austria			12. CITIZEN OF WHAT COUNTRY? No Austria			
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None			17. INFORMANT Mr. Paul Luchansky-Fallston Maryland			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4d d. 1</i>			CARDIO-RESPIRATORY FAILURE						INTERVAL BETWEEN ONSET AND DEATH LESS THAN 6 HR			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			ARTERIO-SCLEROTIC CARDIO-VASCULAR DIS. (c)						2 YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>401 Franklin St. Bldg</i>		(County) <i>Harford Co</i>	(State) <i>Penn</i>		
21. I certify that I attended the deceased from 19 Sept 1959 to 7 Oct 1959 , that I last saw the deceased alive on 19 Sept 1959 , and that death occurred at 6 A.M. from the causes and on the date stated above.											ADDRESS (Street, city or town, state) <i>401 Franklin St. Bldg</i>	DATE SIGNED <i>Oct 1959</i>
ACTUAL SIGNATURE <i>H. P. Sidwell</i>			PHYSICIAN'S NAME (Type) H. P. SIDWELL M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 10-12-1959			22c. NAME OF CEMETERY OR CREMATORIUM St. Michaels Cemetery			22d. LOCATION (City, town, or county) Jessup, Lackawanna Co:Penn.			
23. FUNERAL DIRECTOR'S SIGNATURE George J. Ruth, Inc. - 1735 Harford Avenue Baltimore, Maryland			ADDRESS Baltimore, Maryland			24a. REC'D BY REGISTRAR OCT 9 '59			24b. REGISTRAR'S SIGNATURE Catherine S. Kline			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

is necessary,
please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VII. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.

11470 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Harford	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md.		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewood	b. COUNTY Harford		
c. LENGTH OF STAY IN 16 14 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5 Morgan Court	d. STREET ADDRESS 5 Morgan Court		
3. NAME OF DECEASED (Type or print) William	4. DATE OF DEATH Oct. 17, 1959		
First A.	Middle Matherly		
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Oct. 6, 1915	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Dairy	11. BIRTHPLACE (State or foreign country) Bristol, Tenn.,
13. FATHER'S NAME John D. Matherly		14. MOTHER'S MAIDEN NAME Clara P. Pennington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give award and date of service) yes WW II		16. SOCIAL SECURITY NO. 17. INFORMANT 222-05-0043 Mrs., Nora Matherly, Edgewood, Maryland.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO DUE TO (c)	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? NO <input checked="" type="checkbox"/> YES <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY - Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		DATE SIGNED 10/18/59
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 20, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens
22d. LOCATION (City, town, or country) Bel Air, Harford, Maryland.		(State)	
23. FUNERAL DIRECTOR Howard R. Brown Jr.	ADDRESS Abingdon, Md.,	24a. REC'D BY REGISTRAR OCT 21 1959	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

20 Feb 1981

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10/M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11446

CERTIFICATE OF DEATH

11453

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY HARFORD

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN HAVRE DE GRACE

MARYLAND

LENGTH OF STAY
(In this place)

18 MOS.

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

314 LAFAYETTE ST.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MD

COUNTY HARFORD

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN HAVRE DE GRACE

STREET
ADDRESS

314 LAFAYETTE, ST

(If rural give location)

3. NAME OF
(First) (Middle) (Last)

(Type or Print)

EDWARD L

McFARLAND

4. DATE (Month) (Day) (Year)

OCT 22

1959

5. SEX

6. COLOR OR
RACE

MALE WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify)

MARRIED

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

NIGHT WATCHMAN

10b. KIND OF BUSINESS
OR INDUSTRY

RETIRED

8. DATE OF BIRTH

APR. 5, 1874

(Last)

9. AGE last birthday

85

yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

VA.

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

ROBERT N. McFARLAND

14. MOTHER'S MAIDEN NAME

MARY ELIZABETH MILLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.) (If Yes, give war or dates of service)

NO

NO

16. SOCIAL SECURITY NO.

220-26-0560

17. INFORMANT & ADDRESS

MR. SHIRLEY W. McFARLAND

314 LAFAYETTE, ST HAVRE DE GRACE, MD.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) _____
 ANTECEDENT CAUSE(S) DUE TO _____
 DISEASES OR CONDITIONS, IF ANY, (B) _____
 GIVING RISE TO THE ABOVE CAUSE
 STATING UNDERLYING CAUSE LAST. DUE TO _____
 (C) _____

18. MEDICAL CERTIFICATION

Cerebral Hemorrhage
 Generalized Arthritis chronic

INTERVAL BETWEEN
ONSET AND DEATH

14G

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

M. While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from OCT 19, 1959, to OCT 22, 1959, that I last saw the deceased

alive on OCT 22, 1959, and that death occurred at 7 A.M. from the causes and on the date stated above.

SIGNATURE

1. Edward L. McFarland

4075 Birch Ave

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

BURIAL

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

C. S. Thomas

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

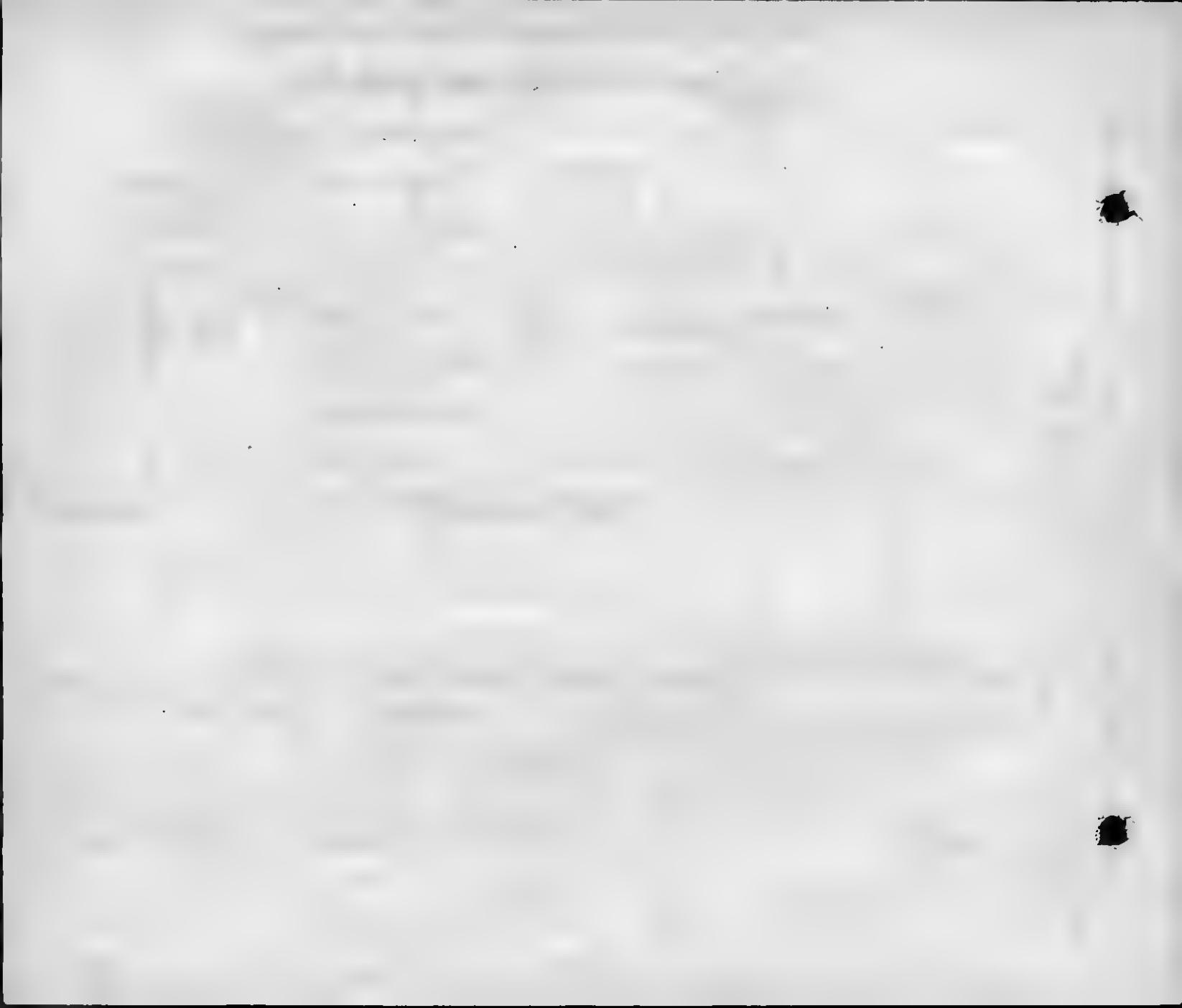
(State)

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

W. Madison Mitchell HAVRE DE GRACE

DATE OCT 28 '59



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11447

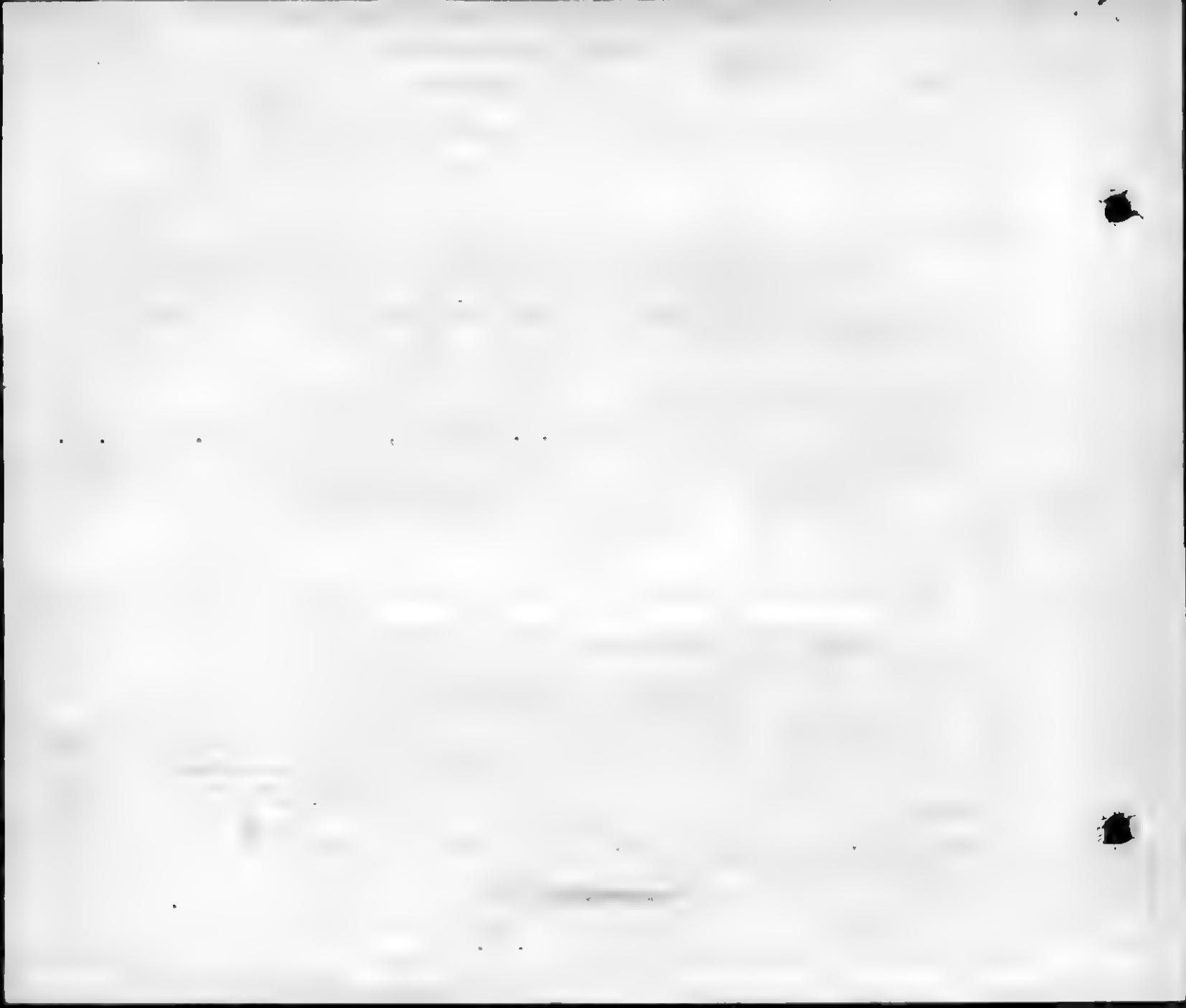
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD		b. COUNTY Ocal		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 30 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		d. STREET ADDRESS 252 N. Main St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial				d. STREET ADDRESS 252 N. Main St.		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John Wesley McMullen		First	Middle	Last	4. DATE OF DEATH October 8 1959	Month	Day	Year
5. SEX Male		6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1879	9. AGE (In years last birthday) 80 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Day		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME William McMullen		14. MOTHER'S MAIDEN NAME Clara Waefield				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) NO		16. SOCIAL SECURITY NO		17. INFORMANT C. S. McMullen, 3203 Elgin Ave., Balto. Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO Myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 10 min				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO atherosclerotic heart disease		(c)				> 10 min		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Port Deposit		(County) MD (State)
21. I certify that I attended the deceased from olive on 10-8-59 , and that death occurred at 11:30 AM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 10-8-59		DATE SIGNED
ACTUAL SIGNATURE B. J. Plunkett Jr.				M.D.				
PHYSICIAN'S NAME (Type) B. J. Plunkett Jr.				Havre de Grace, Md.				
22a. BURIAL/CREMATION, REMOVED (Check) Burial		22b. DATE THEREOF 10-12-1959		22c. NAME OF CEMETERY OR CREMATORIUM Jones Memorial Cem.		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural		
23. FUNERAL DIRECTOR'S SIGNATURE Levra Patterson, Jr.		ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR OCT 13 1959		24b. REGISTRAR'S SIGNATURE Collet & Thomas		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 at 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

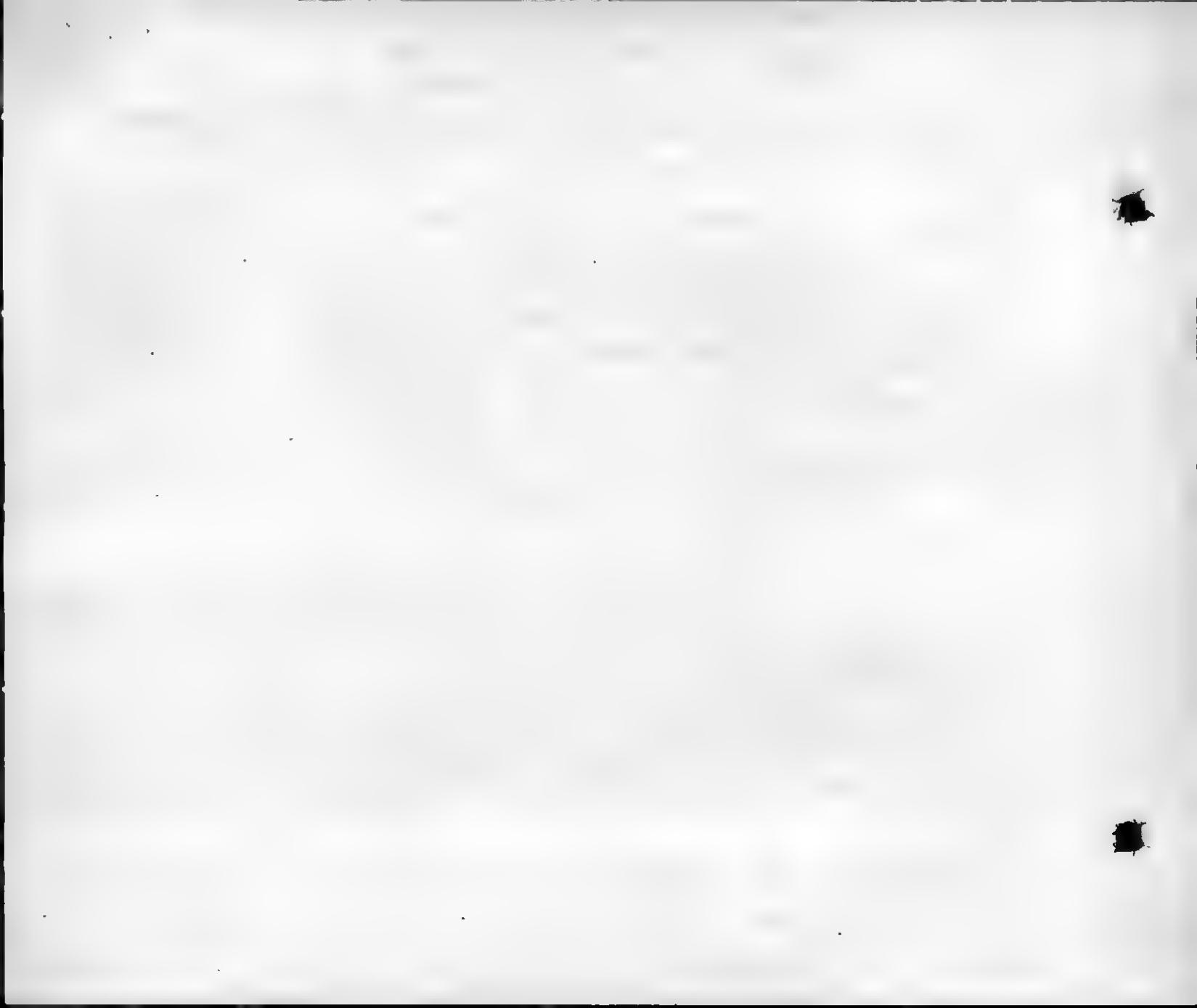
11448

11471

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Emmorton Road		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JAMES		First F.	Middle M.	
4. DATE OF DEATH Oct. 8	Month 1959	Day 8	Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1892	
9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hours 0	13. Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Home Construction		11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.,				
13. FATHER'S NAME L. B. Myers		14. MOTHER'S MAIDEN NAME Camelia Huey		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 242-01-7693		17. INFORMANT L.E. Myers, Address Jonesville, N.C.,
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c) DUE TO		Acute myocardial infarction Coronary thrombosis Arteriosclerotic heart dis		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) N/A		INTERVAL BETWEEN ONSET AND DEATH Approx. 2 hrs		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A		
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19				
21. I certify that I attended the deceased from Oct. 8, 1959, to Oct. 8, 1959, that I last saw the deceased alive on Oct. 8, 1959, 1959, and that death occurred at 4:50 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Warren R. Lesch, M.D. 115 Fulford Bel Air, Md. 10/8/59				
PHYSICIAN'S NAME (Type) Warren R.		Lesch 115 Fulford Bel Air, Md.,		
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Oct. 9, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Reins-Sturdivant F.H.,	22d. LOCATION (City, town, or county) North Wilkesboro, Wilkes, N.C., (State)
23. FUNERAL DIRECTOR'S SIGNATURE Howard W. McCormick		ADDRESS Abingdon, Maryland.	24a. REC'D BY REGISTRAR DATE OCT 13 '59	24b. REGISTRAR'S SIGNATURE C. L. Lewis



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14. Date 11-15-59 et

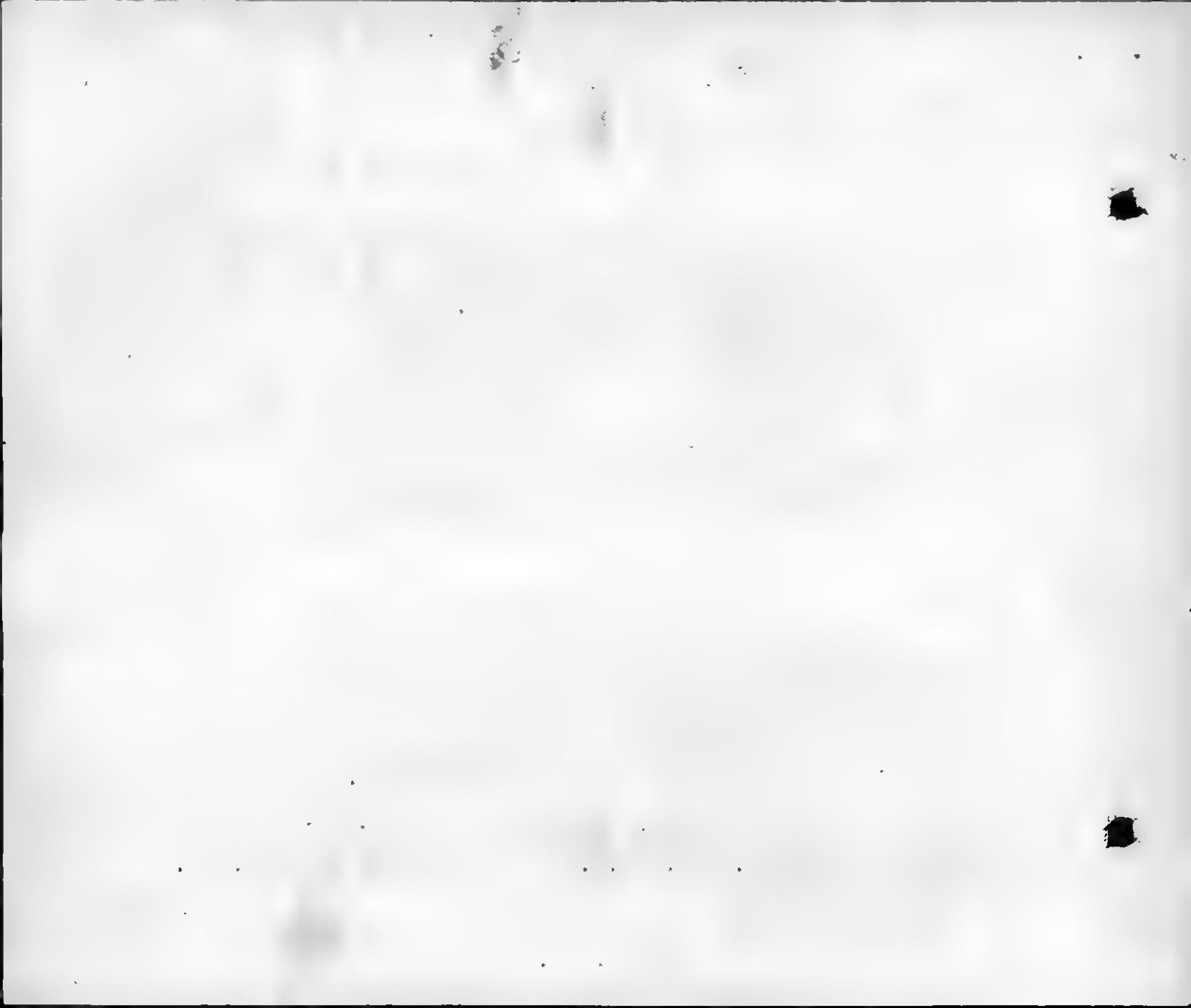
11449

11472

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) JAMES GEORGE PLUMMER				4. DATE OF DEATH Month October Day 31 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 15 Feb. 1882	
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter (Ret)		11. KIND OF BUSINESS OR INDUSTRY Self employed		12. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME James Plummer		14. MOTHER'S MAIDEN NAME Sarah Parks		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) No			
16. SOCIAL SECURITY NO. 215-12-8705				17. INFORMANT Albert Plummer, Forest Hill, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerotic Cardiovascular Disease (c) DUE TO Cardiac Decompensation				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 31st</u> , 1959, to <u>Oct. 31st</u> , 1959, that I last saw the deceased alive on <u>Oct. 31st</u> , 1959, and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Edward C. Loo, M.D.</i>				22a. ADDRESS (Street, city or town, state) 211 N. Union Avenue DATE SIGNED 11/2/59			
22b. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22c. BURIAL, CREMATION, REMOVAL (Specify) Burial		22d. DATE THEREOF 11/3/1959		22e. NAME OF CEMETERY OR CREMATORIAL ADDRESS Mt. Zion Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Tarring</i>		24a. LOCATION (City, town, or county) Bel Air, B. C., Maryland.		24b. REC'D. BY REGISTRAR NOV 5 '59		24c. REGISTRAR'S SIGNATURE <i>Caroline S. Turner</i>	
24d. DATE		24e. ADDRESS Tarring Funeral Home Aberdeen, Md.		24f. DATE		24g. ADDRESS	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11455 CERTIFICATE OF DEATH

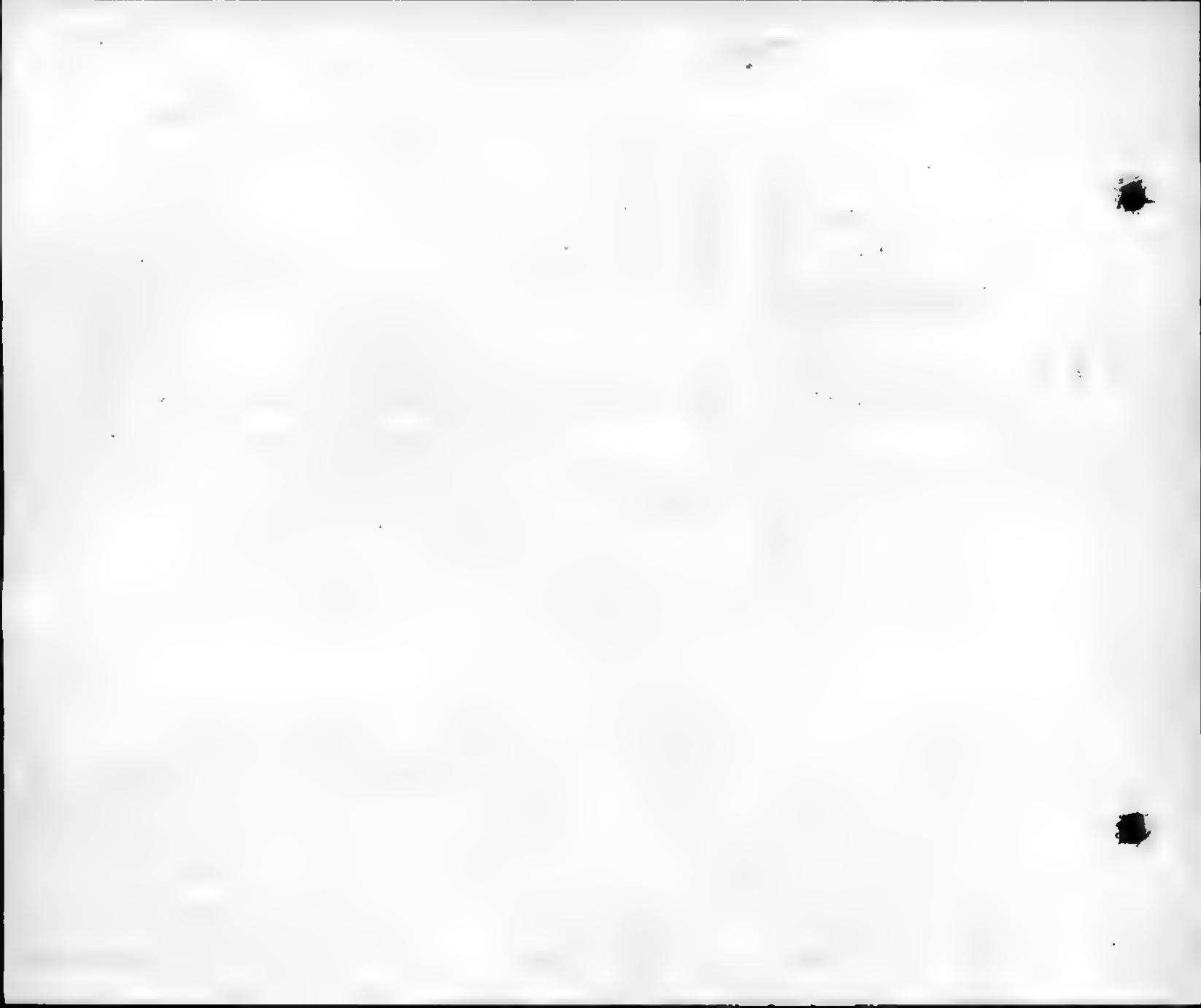
Reg. Dist. No. 11450

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.

1. PLACE OF DEATH a. COUNTY HARFORD	2. USUAL RESIDENCE (Where deceased lived) a. STATE Pa.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD GRACE	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) YORK				
d. LENGTH OF STAY IN b 3 days	d. STREET ADDRESS RD #2				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Samuel WALTER POMRANING	4. DATE OF DEATH October 17 1959				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-59	9. AGE (In years last birthday) yrs 3	10. IF UNDER 1 YEAR Months 3 Hours 0 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	10b. KIND OF BUSINESS OR INDUSTRY Painter	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME Samuel WALTER POMRANING	14. MOTHER'S MAIDEN NAME HELEN SCARBOROUGH				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO (If yes, give war or dates of service) INFORMANT	17. ADDRESS WALTER POMRANING, DELTA, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				19. INTERVAL BETWEEN ONSET AND DEATH Two days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)				20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 10/16 , 1959, to 10/17 , 1959, that I last saw the deceased alive on 10/16 , 1959, and that death occurred at 9:05 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) HAURE DE GRACE, Md.	
ACTUAL SIGNATURE F. H. HATEM	DATE SIGNED 10/17/59				
PHYSICIAN'S NAME (Type) F. H. HATEM					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-18-59	22c. NAME OF CEMETERY OR CREMATORIAL PINE GROVE	22d. LOCATION (City, town, or county) (State) DELTA, YORK, Pa.		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hardin, Delta, Pa.	ADDRESS	24a. REC'D BY REGISTRAR DATE OCT 20 1959	24b. REGISTRAR'S SIGNATURE Charles S. Thomas		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11473

CERTIFICATE OF DEATH

11451

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Darlington		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Darlington				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D.				d. STREET ADDRESS R.F.D.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First AGNES	Middle VIOLA	Last PRESTON	4. DATE OF DEATH October 21 1959	Month October	Day 21	Year 1959
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. B. DATE OF BIRTH Nov. 12, 1885	9. AGE (In years last birthday) 73 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Carty				14. MOTHER'S MAIDEN NAME Annie West				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. LeRoy Hasson, Darlington, Md.		Address R.F.D.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)				Diseasing Aneurysm of Aorta Arterial Hypertension			INTERVAL BETWEEN ONSET AND DEATH 46 hr.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Aberdeen	(County) Caroline	(State) Md.
21. I certify that I attended the deceased from 5-30-59, 19, to 10-21-, 1959, that I last saw the deceased alive on 10-19-59, and that death occurred at 10:30 AM from the causes and on the date stated above. ACTUAL SIGNATURE Peter P. Rodman, M.D. PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D. ADDRESS (Street, city or town, state) 8 Lou St - Aberdeen, Md. DATE SIGNED 10-26-59								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/24/59		22c. NAME OF CEMETERY OR CREMATORIAL Rock Run Cemetery		22d. LOCATION (City, town, or county) R.D. Havre de Grace, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Golic & Barrang - Tarring Funeral Home Aberdeen, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 26 '59	24b. REGISTRAR'S SIGNATURE C. Golic & Barrang	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. LENGTH OF STAY IN lb 10 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.		e. STREET ADDRESS Edgewood 'Box 56	
3. NAME OF DECEASED (Type or print) MARY		First E.	Middle Price
4. DATE OF DEATH October 7 1959		Month October	Day 7
5. SEX FEMALE		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Mar. 18, 1889		9. AGE (In years last birthday) 70 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME GEORGE M. HARDY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none	17. INFORMANT Richard Price, Edgewood, Maryland.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic and Cerebrovascular DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. and Cardiovascular Disease.		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Congestive Heart Failure & Cerebral Thrombosis.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/28 1959 to 10/6 1959 that I last saw the deceased alive on 10/6 1959 , and that death occurred at 550 M. from the causes and on the date stated above.		A. ADDRESS (Street, city or town, state) Box 960 Edgewood, Md DATE SIGNED 10/8/59	
ACTUAL SIGNATURE E. Louis Kahan M.D.		PHYSICIAN'S NAME (Type) E. Louis Kahan	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 10 1959	22c. NAME OF CEMETERY OR CREMATORIUM Cokesbury Memorial
22d. LOCATION (City, town, or county) Abingdon, Harford, Maryland.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Edward J. McNamee Abingdon Md		24a. REC'D BY REGISTRAR DATE OCT 13 '59	24b. REGISTRAR'S SIGNATURE Arthur A. Kahan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11474

CERTIFICATE OF DEATH

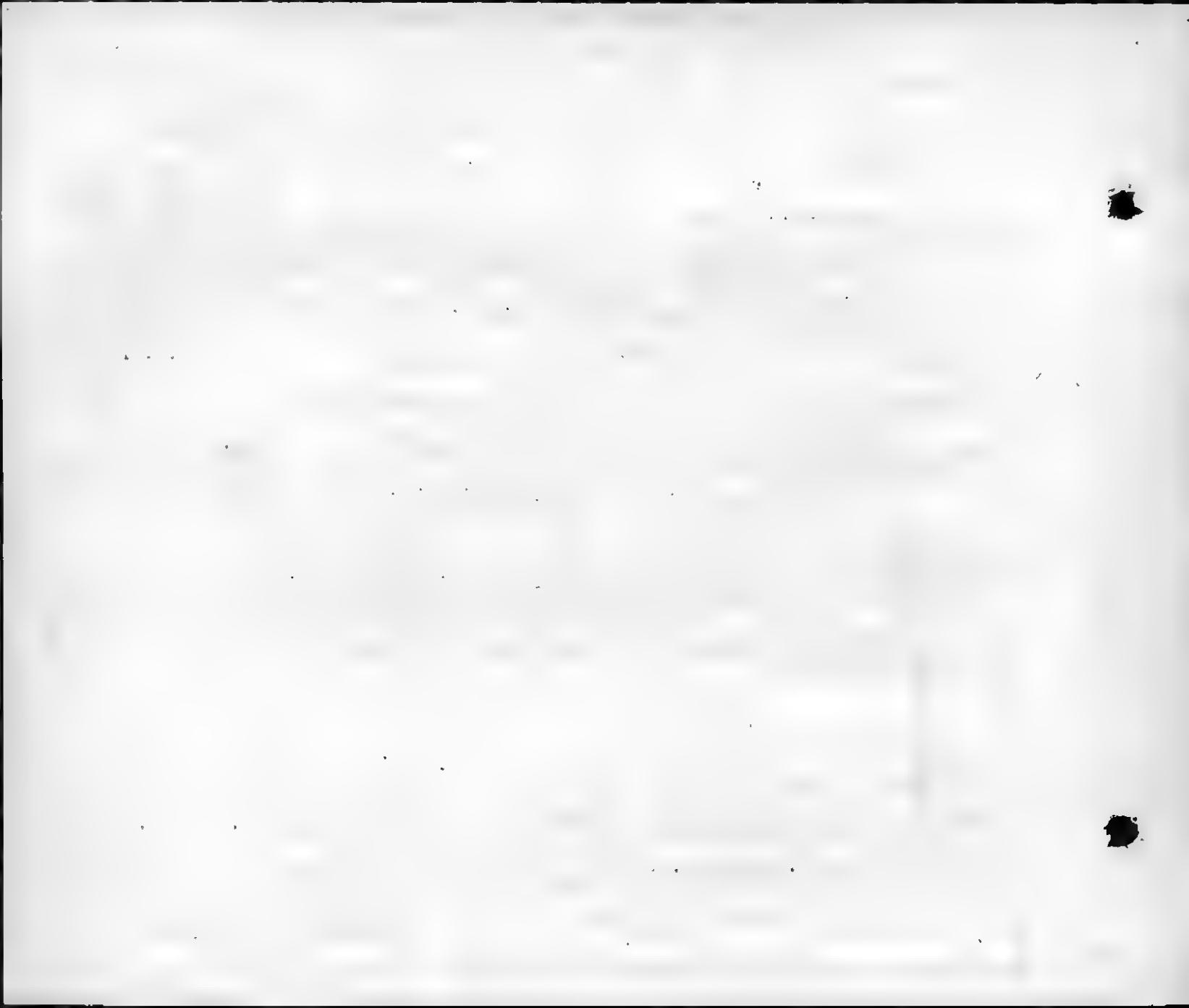
Reg. Dist. No. 11453

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rocks		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Rocks		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Bessie	Middle May	Last Rutherford	4. DATE OF DEATH October 1, 1959	Month October	Day 1	Year 1959
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1889		9. AGE (In years last birthday) 70 yrs	10. IF UNDER 1 YEAR Months 3 Days 26	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Thomas Cook				14. MOTHER'S MAIDEN NAME Victoria Reedy				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT John Rutherford		Address Rocks, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, terminating</u> ? DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c) <u>Chronic decompensated cardio-vascular disease</u> ?								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>March 19, 1946</u> , to <u>Oct. 1, 1959</u> , that I last saw the deceased alive on <u>Oct. 1, 1959</u> , and that death occurred at <u>Forest Hill, Md.</u> from the causes and on the date stated above.								
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.		ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED Oct. 5, 1959						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/7/1959		22c. NAME OF CEMETERY OR CREMATORIAL Centre		22d. LOCATION (City, town, or county) Forest Hill, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kury		ADDRESS Jarrettsville, Md.		24a. REC'D BY REGISTRAR DATE OCT 9 '59		24b. REGISTRAR'S SIGNATURE C. L. & F. Inc.		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filled in by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11454

11457

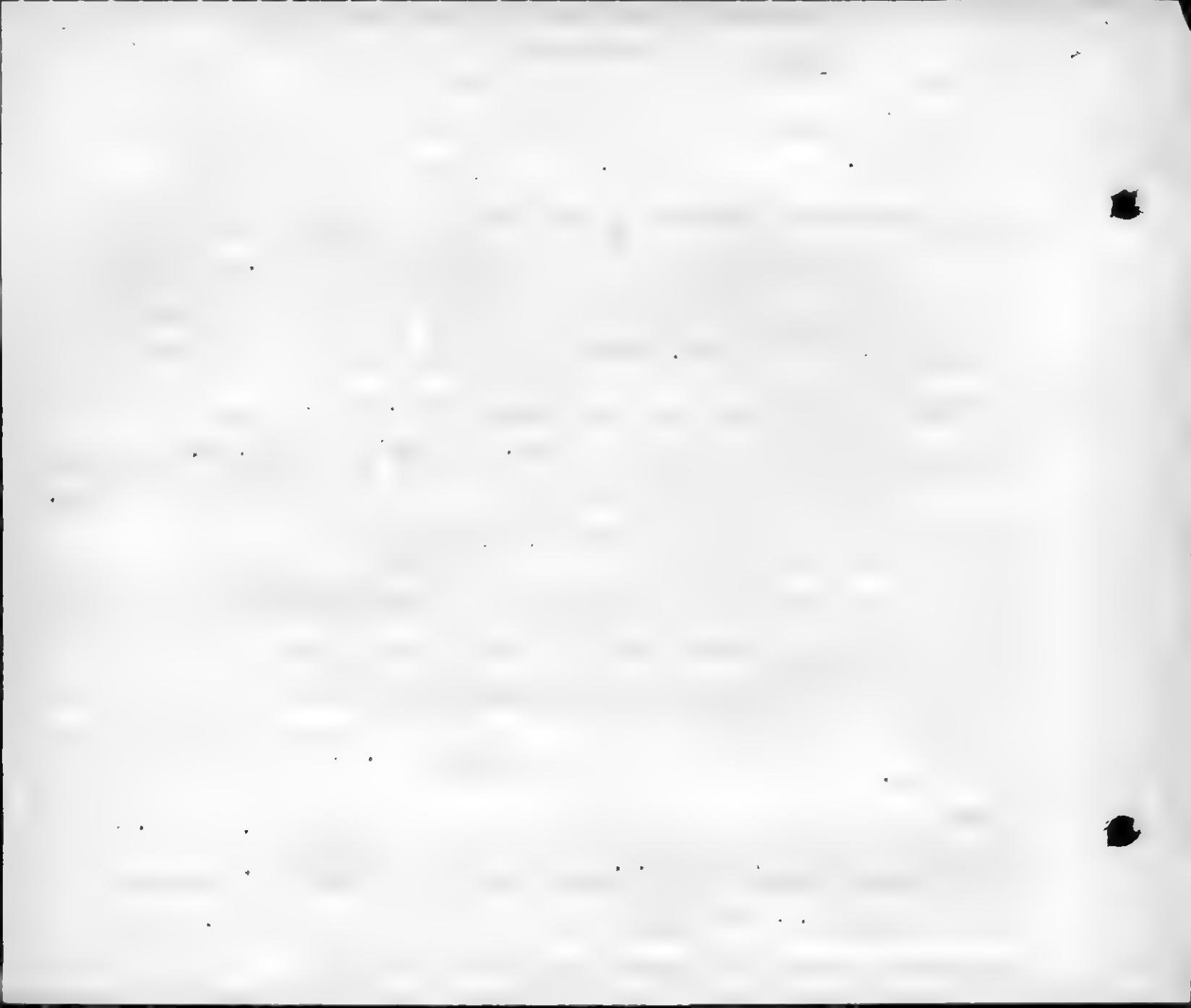
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air, Md.		c. LENGTH OF STAY IN TB 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Hill			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas Winfield Scarff	First	Middle	Last	4. DATE OF DEATH Oct. 6 1959	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 21, 1870	9. AGE (In years last birthday) 89	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 6	12. IF UNDER 24 HRS. Hours 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer retired		10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY/ United States	
13. FATHER'S NAME Charles Tyler Scarff				14. MOTHER'S MAIDEN NAME Martha P. Hitchcock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Mark Hopkins, Bel Air, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 48 Hrs.			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Chronic Cardio Vascular Disease				?			
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1957 to Oct. 6, 1959 , that I last saw the deceased alive on Oct. 6, 1959 , and that death occurred at 4:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED Oct. 7, 1959							
ACTUAL SIGNATURE Willard P. Hudson		PHYSICIAN'S NAME (Type) Willard P. Hudson M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 9, 1959		22c. NAME OF CEMETERY OR CREMATORIAL Friendship		22d. LOCATION (City, town, or county) (State) Fallston, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurl		ADDRESS Jarrettsville, Md.		24a. REC'D BY REGISTRAR DATE OCT 13 '59		24b. REGISTRAR'S SIGNATURE Arthur & Irene	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11455

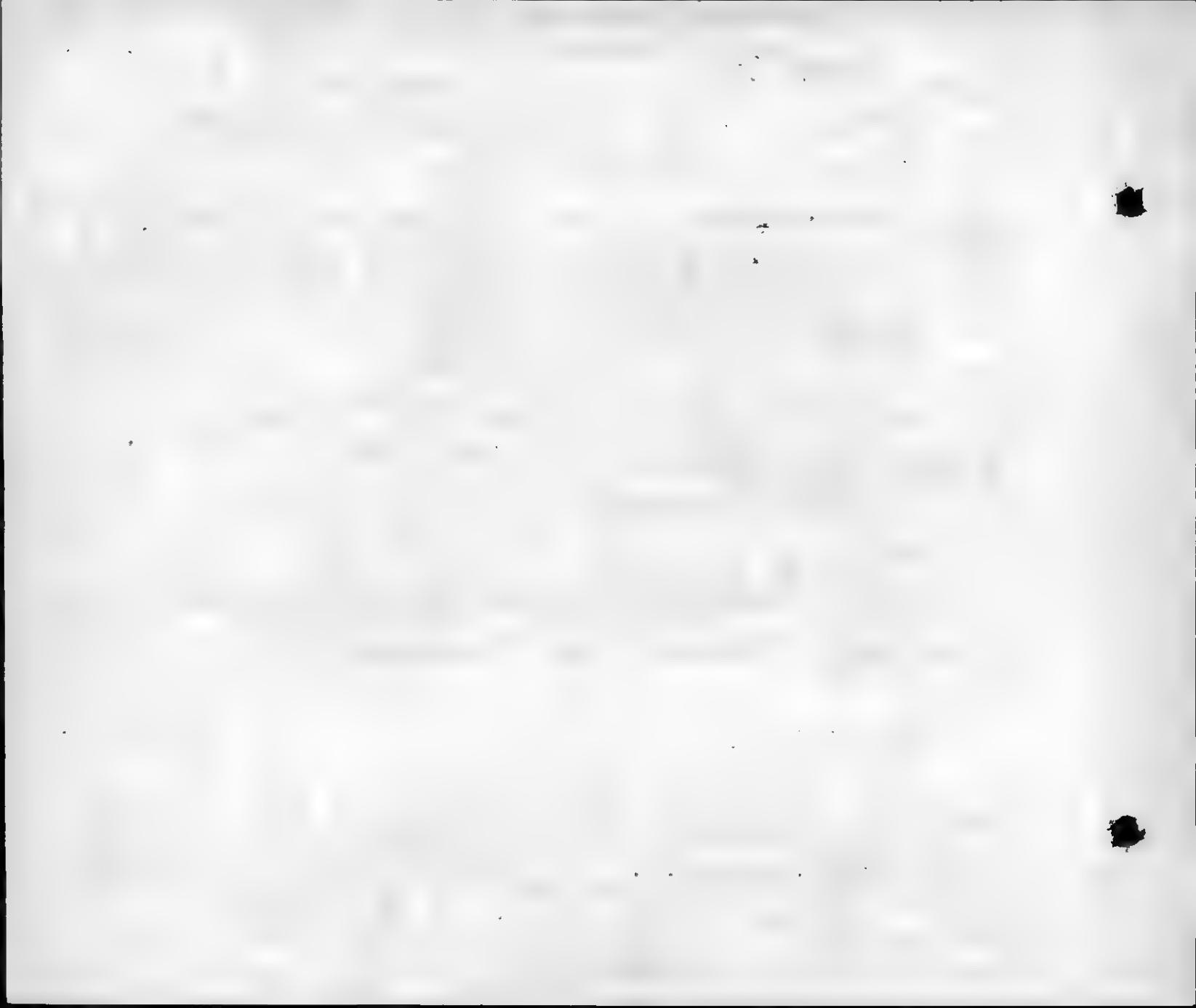
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 3 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent		Reg. Dist. No.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avre de Grace		c. LENGTH OF STAY IN lb 1 1/2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton		d. STREET ADDRESS 147		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Edward E. Tinch		First Edward	Middle E.	Last Tinch	4. DATE OF DEATH October 11, 1959	Month October	Day 11	Year 1959
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH age 37 June 16, 1922		9. AGE (in years last birthday) 36 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 1 1/2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kent CO. Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Sylvester Tinch		14. MOTHER'S MAIDEN NAME Arrie Brown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT 215-16-8572 Florence Tinch KFD		Address Worton, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture skull						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs		
819X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) auto accident auto object type						
20c. TIME OF INJURY Hour 6:00 p.m.		Month, Day, Year 10-11-59	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40	20f. (City or town) Havre de Grace	(County) Harford	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE Gerald C. Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-12-59		
EXAMINER'S NAME (Type) Gerald C. Palmer, M. D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/15/59		22c. NAME OF CEMETERY OR CREMATORIAL Coleman's Cem.		22d. LOCATION (City, town, or county) RFD Worton, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR OCT 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11459

CERTIFICATE OF DEATH

11456

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 132 Law Street		d. STREET ADDRESS 132 Law Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MYRTLE		First GRACE	Middle TWEED
4. DATE OF DEATH October 15 1959		Month Day Year	
5. SEX Female White		6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Feb. 14, 1900
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
10c. BIRTHPLACE (State or foreign country) Penns.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Monroe Guhl		14. MOTHER'S MAIDEN NAME Emma Rutherford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] NO		16. SOCIAL SECURITY NO. *** ***	
17. INFORMANT Dorothy Nichols		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157x DUE TO Hepatic Insufficiency INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Obstructive Jaundice, Hepatitis One week (c) Tumor (prob Cancer) of Pancreas 3 months	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
20g. ADDRESS (Street, city or town, state) 114 W. Bel Air Ave.		21. I certify that I attended the deceased from Oct 14, 1959, to Oct 15, 1959, that I last saw the deceased alive on Oct 14, 1959, and that death occurred at 9:30 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE Andre Weiss M.D. DATE SIGNED 10/16/59	
22. PHYSICIAN'S NAME (Type) Andre Weiss, XXXXXXXX M.D.		22. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 10/18/59 22c. NAME OF CEMETERY OR CEMETORY Spesutia Cemetery 22d. LOCATION (City, town, or county) Perryman, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Farney		24a. ADDRESS Tarring Funeral Home Aberdeen, Md. 24b. REC'D BY REGISTRAR OCT 20 '59 24c. REGISTRAR'S SIGNATURE C. J. S. Kline	

THE STATE GOVERNMENT OF KERALA

CERTIFICATE OF DESIGN

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11457

11475 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Fallston		c. LENGTH OF STAY IN lb Entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston, Md.		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Rebecca		First N.	Middle N.	Last Watson	4. DATE OF DEATH October 16, 1959	Month Oct.	Day 16	Year 1959	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH May 3, 1878	9. AGE (in years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 81	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Fallston, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William T. Watson		14. MOTHER'S MAIDEN NAME Elizabeth Amoss							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT James O. Watson		Address Fallston, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Coronary Occlusion		DUE TO 420.1		DUE TO Chr. Cardio-vascular disease		INTERVAL BETWEEN ONSET AND DEATH 30 min.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. -----		DUE TO (b)		DUE TO (c)		10 yr. -----			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Forest Hill, Md.		(County) -----	(State) -----
21. I certify that I attended the deceased from Oct. 13, 1949 , to Oct. 16, 1959 , that I last saw the deceased alive on Oct. 13, 1959 , and that death occurred at 6:40 a.m. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) Forest Hill, Md.									
DATE SIGNED 10/17/59									
ACTUAL SIGNATURE Willard P. Hudson		M.D.							
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.		Forest Hill, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/18/1959		22c. NAME OF CEMETERY OR CREMATORIAL Friends Meeting		22d. LOCATION (City, town, or county) Fallston		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles C. Kurt		ADDRESS Jarretsville, Md.		24a. REC'D BY REGISTRAR DATE OCT 19 '59		24b. REGISTRAR'S SIGNATURE Charles S. Knapp			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

